Complete Summary

GUIDELINE TITLE

Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection.

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention (CDC). Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection. MMWR Recomm Rep 2008 Nov 7;57(RR-9):1-83; quiz CE1-4. [243 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Syphilis
- Gonorrhea
- Chlamydial infection

GUIDELINE CATEGORY

Counseling
Management
Prevention

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Physicians
Public Health Departments
Social Workers

GUIDELINE OBJECTIVE(S)

- To provide updated, integrated recommendations for services provided to partners of persons with human immunodeficiency virus (HIV) infection and three other sexually transmitted diseases (STDs) (i.e., syphilis, gonorrhea, and chlamydial infection)
- To replace the Centers for Disease Control and Prevention (CDC) 2001 Program Operations Guidelines for STD Prevention—Partner Services and the 1998 HIV Partner Counseling and Referral Services Guidance

TARGET POPULATION

Persons with human immunodeficiency virus (HIV) infection, syphilis, gonorrhea, or chlamydial infection and their partners

INTERVENTIONS AND PRACTICES CONSIDERED

1. Consideration of legal and ethical concerns
2. Identifying index patients
3. Prioritizing index patients
4. Interviewing index patients
5. Risk reduction strategies for index patients
6. Treatment for index patients
7. Referring index patients to other services
8. Notifying partners of exposure
9. Risk reduction interventions for partners
10. Cluster interviewing of partners
11. Testing partners
12. Treatment for partners
13. Referring partners to other services
14. Consideration of specific populations, including youth, immigrants and migrants, and incarcerated populations

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Centers for Disease Control and Prevention (CDC) led a work group that planned and coordinated the process of revising and combining two existing guideline documents into a single set of recommendations. Simultaneously, numerous organizations and experts with potential interest in partner services were notified that the guidelines were being revised and invited to provide input; approximately 70 stakeholder groups were included in this process. In addition, an extensive review was conducted to identify relevant published research.

During 2005–2006, CDC sought input from attendees at five national human immunodeficiency virus (HIV) and sexually transmitted disease (STD) conferences. Detailed reviews of HIV partner services programs were conducted at eight health departments (six state health departments and two city health departments) to identify current program practices and challenges and to obtain input from persons directly involved in delivering partner services. Discussions with focus groups of potential and actual recipients of HIV partner services were held in five cities to elicit information about experiences with and perceptions of these services. In addition, discussions with focus groups of private clinicians were held in seven cities to assess their level of awareness and understanding of partner services and their perceptions of the importance and effectiveness of such services. Finally, a detailed review was conducted of state laws related to HIV partner services to identify legal concerns and provide a framework of the legal and regulatory environment in which partner services are delivered.

A draft of recommendations was developed and in November 2006, a meeting was convened in Atlanta, Georgia, to obtain input. The meeting was attended by approximately 70 participants from 23 states and the District of Columbia (DC). Participants included representatives of other federal agencies; state and local HIV and STD health department directors, program managers, and staff members; academic research experts; ethicists; representatives from legal, medical, and other professional organizations; and representatives from community-based organizations (CBOs), correctional facility health organizations, community advocacy groups, and training centers with expertise in partner services.

After the meeting, CDC convened seven workgroups, which included CDC staff members and non-CDC participants recruited from the meeting, to revise the draft of the recommendations based on input from meeting participants. In January 2008, a revised draft was distributed for review to federal agencies, health departments, academic and research centers, professional organizations, CBOs, and community advocacy groups. In compliance with requirements of the Office of Management and Budget for influential scientific assessments, CDC also solicited reviews from nonfederal subject-matter experts. The recommendations were revised after reviewer comments were received.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developer reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

In January 2008, a revised draft was distributed for review to federal agencies, health departments, academic and research centers, professional organizations,

community-based organizations (CBOs), and community advocacy groups. In compliance with requirements of the Office of Management and Budget for influential scientific assessments, the Centers for Disease Control and Prevention (CDC) also solicited reviews from nonfederal subject-matter experts. The recommendations were revised after reviewer comments were received.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

How These Recommendations Differ from Previous Partner Services Guidelines

These recommendations integrate previously separate guidelines for partner services for human immunodeficiency virus (HIV) infection, syphilis, gonorrhea, and chlamydial infection into a single set of recommendations. These recommendations have increased emphasis on the following:

- Integration of services at the client level
- Linkage between surveillance and program activities to help ensure that partner services are offered to all persons who test positive for HIV and early syphilis
- Direct public health program involvement in partner services as quickly as possible after diagnosis
- Rationale for selection of the preferred notification strategy for each disease
- Active linkage to medical and prevention services for persons identified as infected with HIV
- Collaboration with internal and external partners involved in all aspects of partner services, including ensuring that partner services are available for all HIV-infected persons throughout the prevention and care continuum
- Program monitoring and evaluation and quality improvement
- A focus on which types of activities HIV and sexually transmitted disease (STD) programs should be performing rather than precisely how they should be performing them

The 1998 *HIV Partner Counseling and Referral Services Guidance* used the term partner counseling and referral services rather than contact tracing or partner notification to describe the type and range of public health services recommended for sex and drug-injection partners of HIV-infected persons. The 2001 *Program Operations Guidelines for STD Prevention* used the term partner services to describe similar activities. This report uses the term partner services to describe services offered to persons with HIV or other STDs. The term partner services is broad and encompasses services typically included in partner counseling and referral services and other services (e.g., screening for other STDs, screening for chronic infection with hepatitis B virus [HBV] and hepatitis C virus [HCV], and vaccination for hepatitis A virus [HAV] and HBV). In addition, the principles of notifying an exposed person do not differ substantially among diseases, and persons with STDs other than HIV often need the same array of services as persons with HIV infection. Using the same term for partner services for HIV and other STDs emphasizes these points.

Legal and Ethical Concerns

- Public health agencies responsible for partner services should conduct a thorough review of all laws relevant to their provision of these services. This review should serve as a basis for developing policies and procedures for partner services programs. Program managers should also ensure that program staff members understand the implications these laws have for conducting partner services. Laws relevant to provision of these services include the following:
    - The legal authority for the public health agencies for partner services
    - Provisions related to privacy and confidentiality (e.g., requirements of the Health Insurance Portability and Accountability Act [HIPAA])
    - Provisions related to duty or privilege to warn and criminal transmission and exposure
    - The ability of the public health agencies to coordinate with other agencies (e.g., law enforcement)
- Program managers should ensure that their staff members understand the legal basis for their work, legal restrictions on their practice (e.g., duty or privilege to warn), the extent to which they are protected from civil litigation, and how to coordinate with law enforcement officials in ways that protect the civil and procedural rights of the persons involved.
- To ensure that program staff members invoke their duty or privilege to warn appropriately, partner services programs should have written policies and procedures to guide staff members in handling complex cases. Guidelines and protocols should be based on the jurisdiction's statutory and case law and developed in consultation with legal counsel. Legal counsel should also be consulted regarding specific cases in which duty to warn or privilege to warn might apply.
- Program managers should be aware of the applicable laws regarding criminal transmission and exposure in their jurisdictions and should coordinate with legal counsel regarding specific cases in which allegations of criminal transmission or exposure are made.

Identifying Index Patients

General

- All persons with newly diagnosed or reported early syphilis infection should be offered partner services. All persons with newly diagnosed or reported HIV infection should be offered HIV partner services at least once, typically at diagnosis or as soon as possible after diagnosis. Partner services program managers should develop strategies with written policies, procedures, and protocols for identifying as many persons as possible with newly diagnosed or reported infection and ensuring that they are offered services.
- Resources permitting, all persons with newly diagnosed or reported gonorrhea should be offered partner services. Programs should consider which resources and services they can devote to partner services for chlamydial infection. Persons with newly diagnosed or reported chlamydial infection should either be offered partner services (e.g., as are those with gonorrhea), or programs should plan alternative strategies to enable partners to be notified.
- Partner services programs should use surveillance and disease reporting systems to assist with identifying persons with newly diagnosed or reported

HIV infection, syphilis, gonorrhea, or chlamydial infection who are potential candidates for partner services. To maximize the number of persons offered partner services, health departments should strongly consider using individual-level data, but only if appropriate security and confidentiality procedures are in place (see Appendix D in the original guideline document). At a minimum, health departments should use provider- and aggregate-level data from their surveillance systems to help guide partner services.

- Strategies for identifying potential index patients for partner services should be carefully monitored and evaluated for completeness, timeliness, effectiveness, and cost-effectiveness.
- Partner services programs should establish and adhere to strict, jurisdiction-specific guidelines, policies, and procedures for information security and confidentiality. These should incorporate the guiding principles and program standards (see Appendix D in the original guideline document) and should adhere to all applicable laws. They should be applied to all individual-level information used by partner services programs, including hard-copy case records and electronic-record systems or data-collection systems.
- All partner services and surveillance programs that share information should meet the minimum security and confidentiality standards (see Appendix D in the original guideline document).
- Penalties for unauthorized disclosure of information should exist for both surveillance and program staff members. All staff members should be informed of these penalties to ensure that data remain secure and confidential.
- For successful sharing of individual-level information, open communication channels between surveillance and partner services programs, adequate resources, clear quality-assurance standards, community inclusion and awareness of the processes, recognition of the rights of infected persons, and sensitivity to health-care providers' relationships with their patients are all needed.
- Jurisdictions that plan to initiate use of disease reporting data to prompt partner services should consider information flow, develop written protocols, and pilot test the proposed system. Protocols should cover practical considerations, such as which types of information will be shared and who will have access, staffing, security measures, and methods for evaluating the system.
- To ensure that appropriate policies and procedures are developed and followed, partner services programs should designate an overall responsible party (ORP) who has responsibility for the security of the program's information collection and management systems, including processes, data, information, software, and hardware. Preferably, a single person should serve as the ORP of both the surveillance and partner services programs.
- Partner services programs that involve community-based organizations (CBOs) in partner services (e.g., for interviewing index patients receiving diagnoses in their counseling and testing programs) should assess the CBOs' ability to meet the minimum standards for data security. CBOs that cannot meet these minimum standards should have limited access to data, although they can still participate in partner services.

HIV Infection

- HIV partner services programs should collaborate with health-care providers who provide HIV screening or testing, other HIV counseling and testing providers, HIV care providers, and HIV case managers to ensure that their clients and patients are offered HIV partner services as soon as possible after diagnosis and on an ongoing basis, as needed.
- HIV partner services programs should work with providers of anonymous HIV testing services to develop strategies for providing partner services to persons who test positive, even if the person decides not to enter a confidential system. These providers should be trained on how to offer partner services and elicit partner information from persons with newly diagnosed HIV infection.

Prioritizing Index Patients

General

- Program managers should establish criteria for prioritizing index patients to determine which patients will be interviewed first. In general, these criteria should include behavioral and clinical factors that affect the likelihood of additional transmission. Pregnant women should always be considered a high priority, regardless of behavioral or other clinical factors.
- Persons with evidence of ongoing risk behaviors for transmission (e.g., recurrent STDs or being repeatedly named as a partner of other infected persons) might be playing an important role in transmission in the overall community and should be prioritized for partner services.

Syphilis

- Many program areas use a reactor grid to assist with determining investigative priorities for syphilis reactors. The reactor grid is based on age and syphilis serology laboratory results (titers). Programs that use a reactor grid are strongly encouraged to validate its performance annually and during suspected outbreaks.

Interviewing Index Patients

General

- In general, partner names should be elicited (partner elicitation) during the original interview. If this is not possible, a reinterview should be scheduled.
- Programs should establish clear policies and procedures for the timing of interviews relative to date of diagnosis or report.
- Index patients should be provided information about the following:
    - The purpose of partner services
    - What partner services entail
    - Benefits and potential risks of partner services for index patients and their partners, and steps taken to minimize any risks
    - How and to what extent privacy and confidentiality can be protected
    - The right to decline participation in partner services without being denied other services
    - Options available for notifying partners

- Program managers should ensure that policies and protocols are in place to safeguard the confidentiality of information shared with health department staff members during the partner notification process. Specifically, staff members must be trained to maintain confidentiality in both their professional and private lives. Confidentiality is particularly salient in rural areas, where a disease intervention specialist (DIS) might have substantial contact with clients outside of the professional environment (e.g., because they are neighbors, parents of children's classmates, or members of the same church).
- To ensure confidentiality, interviews should not be conducted with other persons present, except for quality assurance or for interpreting.
- In general, partner-elicitation interviews should be conducted by trained health department specialists. However, to expand partner services coverage, health departments should consider enlisting other types of providers to conduct interviews on their behalf. Successfully eliciting information about partners requires skilled counseling and interviewing; therefore, all providers conducting interviews on behalf of the health department should receive appropriate training. The yield of interviews conducted by other providers should be carefully monitored.
- In general, interviews should be conducted in person. Telephone interviews might be conducted if no reasonable alternative exists, with strict safeguards in place to verify the identity of the person being spoken with and ensure that privacy and confidentiality are protected.
- Programs should use interview techniques that maximize the amount of information gathered in the original interview about the index patient's partners. Policies, procedures, and protocols should establish criteria for instances in which reinterviews should be done, how soon they should be done, and when they are unnecessary. The yield of original interviews and reinterviews should be monitored closely and policies, procedures, and protocols adjusted accordingly.
- In addition to information about partners, interviewers also can elicit information about the index patient's social network, including venues frequented, for use in planning additional prevention activities.
- Policies, procedures, and protocols should address circumstances that might require specific consideration in interviews with index patients (e.g., age and developmental level, literacy, language barriers, hearing or visual impairment, alcoholism or abuse of other substances, mental health concerns, or potential violence).

Syphilis, Gonorrhea, and Chlamydial Infection

- For early stages of syphilis, policies, procedures, and protocols should specify that all index patients receive an original interview as close to the time of diagnosis and treatment as possible. Every reasonable effort should be made to ensure the partner notification process begins on the date of the original interview.
- For cases of gonorrhea and chlamydial infections that partner services staff members will follow up, policies, procedures, and protocols should specify that all index patients receive an original interview as close as possible to the time of diagnosis and treatment. Unless the index patient has evidence of recent infection, notification primarily serves case-finding goals and might be briefly delayed, if necessary.

- For cases of gonorrhea and chlamydial infection that partner services staff members will not follow up, patient referral instructions should be provided as close as possible to the time of diagnosis and treatment.
- For STDs other than HIV, partner services programs should follow established recommendations for interview periods (see Table below).

Table. Interview Periods* for Partner Services Programs for Chlamydial Infection, Gonorrhea, Human Immunodeficiency Virus (HIV) Infection or Acquired Immunodeficiency Syndrome (AIDS), and Syphilis

Disease	Interview Period
Chlamydial Infection	
Symptomatic	60 days before onset of symptoms through date of treatment
Asymptomatic	60 days before date of specimen collection (through date of treatment if patient was not treated at time specimen was collected)
Gonorrhea	
Symptomatic	60 days before onset of symptoms through date of treatment
Asymptomatic	60 days before date of specimen collection (through date of treatment if patient was not treated at time specimen was collected)
HIV Infection, AIDS	1 or 2 years before date of first positive HIV test through date of interview, might be mitigated by evidence of recent infection or availability of verified previous negative test results All current or former spouses during 10 years before diagnosis
Syphilis*	
Primary	4 months and 1 week before date of onset of primary lesion through date of treatment
Secondary	8 months before date of onset of secondary symptoms through date of treatment
Early latent	1 year before start of treatment

*The time interval for which an index patient is asked to recall sex or drug-injection partners.

**The interview period is based on patient diagnosis and incorporates all maximum time periods. The interview period is not shortened, regardless of patient symptoms, serological history, or incidental treatment. If the patient claims having had no partners during the interview period, then the most recent partner before the interview period should be identified and notified.

HIV Infection

- Policies, procedures, and protocols should specify that all index patients receive an original interview as soon as possible after diagnosis, ideally within a few days. For index patients who are not willing or able to provide partner information during the original interview, a reinterview should be scheduled, preferably no later than 2 weeks after contact was first made (and sooner, if possible, for index patients with acute infections).
- Programs should develop criteria for establishing the interview period for index patients with HIV infection (see Table above). Criteria for prioritizing partners should be developed in consultation with persons who have expertise in clinical and laboratory aspects of HIV (e.g., viral and serologic markers of HIV infection).
- Program managers should ensure that policies and procedures regarding notification of spouses adhere to requirements of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Amendments of 1996 and any other applicable laws.
- Policies, procedures, and protocols should address interviews for persons with reactive rapid HIV tests, including when partner names should be elicited, when partners should be notified, and policies about notifying partners when a confirmatory test is not available.

Risk-Reduction Interventions for Index Patients

- Program managers should develop protocols that establish the minimum amount of information and prevention messages that should be provided to all index patients. For patients with HIV infection, the information should include the index patients' responsibility for disclosing their HIV serostatus to current and future partners.
- Program managers should develop protocols for screening HIV index patients for current or recent behavioral risks and other factors that facilitate transmission. Screening should include asking all HIV index patients about possible signs or symptoms of other STDs, which enhance risk for HIV transmission and indicate current or recent risky sex behaviors.
- Protocols should address management of HIV index patients with risky sex or drug-injection behaviors or who have signs or symptoms of any type of STD. All index patients with ongoing risk behaviors or recurrent STDs of any type should be provided prevention counseling or referred for counseling or other prevention interventions.
- Program managers should assess the program's capacity for providing prevention counseling to all index patients without interfering with partner elicitation. For partner services programs that do not have the internal capacity to regularly provide prevention counseling to all index patients or are limited by resource or logistical factors, program managers should establish formal relationships with other agencies that can provide prevention counseling and more intensive behavioral intervention services and develop clear policies and procedures for making and following up on referrals.
- Program managers should develop protocols to ensure that DISs conducting prevention counseling receive adequate training and supervision and should ensure that quality assurance plans are in place.

Treatment for Index Patients

Syphilis, Gonorrhea, and Chlamydial Infection

- Program managers should ensure that patients are treated according to Centers for Disease Control and Prevention (CDC) treatment guidelines for timely and efficacious treatment with appropriate instructions and attention to recommendations regarding the importance of follow-up testing.

HIV Infection

- Program managers should create strong referral linkages with HIV care providers and case managers to help ensure that the medical needs of index patients are addressed.
- HIV-infected index patients who are not receiving medical care should be referred or directly linked to medical care or to case managers who can then link them to care services.

Referring Index Patients to Other Services

- Because of the diverse needs of many index patients with HIV infection and other STDs, program managers should identify resources for psychosocial and other support services. DISs routinely should be provided updated information about referral resources.
- Many referral needs can be addressed through linkage to medical care and HIV case management; however, DISs should screen for immediate needs and make appropriate referrals.

Notifying Partners of Exposure

Partners

- All identified partners should be notified of their possible exposure as soon as possible, typically within 2 to 3 working days of identification, unless a potential for partner violence exists.
- Program managers should ensure that protocols include screening for potential violence with each partner named before notification. If the provider considers a violent situation possible, the provider should seek expert advice before proceeding with notification. DISs should follow up on referrals for partner violence services to verify that referred persons are safe and have accessed these services.
- Programs should establish criteria for prioritizing the order in which partners are notified. Criteria should be based on behavioral and clinical factors that confer a higher likelihood of the partner having been infected as a result of exposure or, if already infected, of transmitting infection to others. In addition, the Ryan White CARE Act Amendments of 1996 require that states receiving funds under part B of title XXVI of the Public Health Service Act should ensure that a good-faith effort is made to identify spouses of HIV-infected patients. Criteria should be reviewed at regular intervals (at least annually).
- Programs should accommodate various notification strategies that allow the DIS and index patient to collaborate on the best approach for notifying each partner of exposure and ensure that the partner receives appropriate counseling and testing. Regardless of which strategy is used, the DIS and index patient should plan for potential unanticipated outcomes.

- For partners for whom the index patient has provided a name (or other identifying information, such as an alias) and locating information, programs should strongly encourage provider referral but be supportive of index patients who choose contract referral for selected partners.
- When contract referral is chosen, the DIS should establish an agreement with the index patient specifying when partners should be notified (typically within 24 to 48 hours), how the provider will confirm that partners were notified, and which follow-up services will be required for situations in which the index patient does not notify the partner within the allotted time frame.
- Programs should allow for self-referral as permitted by state and local laws and regulations. Index patients who choose self-referral for certain or all partners should be informed of its disadvantages and informed about methods for accomplishing the notification safely and successfully. Self-referral should be discouraged if screening indicates a potentially violent situation.
- Protocols for self-referral should, when possible, incorporate interventions that enhance its effectiveness and include instructing the index patient about the following:
    - When to notify the partner (e.g., within 24 to 48 hours)
    - Where to notify the partner (e.g., private and safe setting)
    - How to tell the partner
    - How to anticipate potential problems and respond to the partner's reactions
    - How and where the partner can access counseling and testing for HIV and other types of STDs
    - For persons with HIV infection, how to address the psychological and social impact of disclosing infection status to others
    - How to contact the DIS with any questions or concerns that might arise
- To the extent possible, programs should develop methods of monitoring whether partners who are to be notified by the index patient (i.e., via contract or self-referral) are actually notified and receive appropriate counseling and testing.
- Dual referral should be an option for index patients who prefer to be directly involved in the notification but express a need for assistance and support from the DIS. When dual referral is chosen, the DIS and index patient should plan in advance how the session will be conducted.
- Program managers should ensure that policies and procedures, consistent with applicable laws, are in place to protect the identities of index patients when informing partners of their exposure and to ensure that information about partners is not reported back to index patients.
- Local reporting laws relating to domestic violence, including child abuse and abuse of older adults, must be followed when clients report risk or history of abuse.
- Program managers should ensure that DISs are the following
    - Knowledgeable about HIV and STD infections, transmission, and prevention
    - Well informed about relevant laws and regulations
    - Familiar with HIV and STD program standards, objectives, and performance guidelines
    - Culturally competent in providing partner services

- Skilled at problem solving and dealing with situations that might be encountered in the field (e.g., personal safety, intimate partner violence, violence to others)
- Trained how to screen for and address partner violence concerns

Social Contacts

General

- In general, notification of partners should have a higher priority than notification of individual social contacts identified through clustering. Routine follow-up of social contacts should be carried out only after the program is successfully interviewing most new patients with cases and locating and notifying most partners and only after carefully considering the potential case-finding yield and resource implications. If this strategy is used, the number of cases identified should be carefully monitored, and the approach should be continued only if its effectiveness and cost-effectiveness equal or exceed those of other case-finding strategies. Notification of social contacts might be given higher priority during an outbreak.

HIV Infection

- For persons with HIV infection, information about social contacts should be used as an aid to understanding transmission dynamics in the community and to help guide additional prevention interventions at the community level (e.g., screening and social marketing). In general, if individual social contacts are to be recruited for HIV testing, a self-referral approach rather than provider referral should be used. A provider referral approach should be used only after careful consideration of potential individual and community concerns about privacy and confidentiality. Provider referral might be appropriate during an outbreak.

Risk-Reduction Interventions for Partners

- Program managers should develop protocols that describe the minimum amount of general information and prevention messages that should be provided to all partners at the time of notification.
- All partners of STD/HIV-infected index patients should receive prevention counseling.
- Because a substantial proportion of partners decline to or do not keep appointments for counseling and testing, prevention counseling should be provided by the DIS at the time of notification.
- Prevention counseling should be based on counseling models that have demonstrated efficacy (e.g., the Project RESPECT model).
- Program managers should develop protocols for screening partners to determine whether they need additional risk-reduction interventions and refer them for such interventions.
- Program managers should develop protocols to ensure that DISs conducting prevention counseling receive adequate training and supervision and ensure that quality improvement plans are in place.

Cluster Interviewing Partners

General

- When notifying partners of their possible exposure, DISs might also elicit information about the partners' social networks, including venues frequented, for use in planning additional prevention activities.
- In general, notification of partners should be prioritized over follow-up of individual associates identified through cluster interviews. Routine follow-up of associates should be done only after the program is successfully interviewing most new patients with cases and locating and notifying most partners, and only after carefully considering the potential case-finding yield and resource implications. If this strategy is used, its case-finding yield should be carefully monitored, and the strategy should be continued only if its effectiveness and cost-effectiveness equal or exceed those of other case-finding strategies. Follow-up of associates might be given higher priority during an outbreak.

HIV Infection

- For persons with HIV infection, information about associates should be used as an aid to understanding transmission dynamics in the community and to help guide additional prevention interventions at the community level (e.g., screening and social marketing). In general, if individual associates are to be recruited for HIV testing, a self-referral approach rather than provider referral should be used. A provider referral approach should be used only after careful consideration of potential individual and community concerns about privacy and confidentiality. A provider referral approach might be appropriate during an outbreak.

Testing Partners

General

- To the extent possible, testing for HIV and other types of STDs should be done at the time of notification. Partners who are not tested at the time of notification should be escorted or referred to the health department for testing or linked to other health-care providers who can provide these services.
- DISs should follow up on partners not tested at the time of notification to verify that testing has occurred, test results were received and understood, and other referral services were accessed. If another health jurisdiction has been asked to contact a partner, follow up should be conducted by the initiating health department to determine whether services have been received.
- Program managers should explore ways in which screening for HIV, screening and treatment for other types of STDs, screening for HBV and HCV, and vaccination for HAV and HBV might be integrated in partner services programs.

Syphilis

- Blood should be drawn in the field when DISs are trained to do so and when specimen maintenance conditions can be met. Partners should be referred for evaluation regardless of whether a specimen has been collected.

Gonorrhea and Chlamydial Infection

- If provider referral is used, programs should consider protocols for collecting specimens in the field.

HIV Infection

- Partner services programs should consider using rapid HIV tests to maximize the number of partners who are tested and receive test results.
- When notification is done in the field, rapid tests should be used or a blood or an oral fluid specimen should be collected for conventional testing. If neither of these is possible, the partner should be escorted or referred to the clinic for testing.
- Partners who test negative for HIV antibody should be advised to be retested in 3 months.

Treatment for Partners

Syphilis, Gonorrhea, and Chlamydial Infection

- Program managers should ensure that partners are treated according to CDC treatment guidelines as soon as possible after notification.
- Programs should consider field-delivered therapy (FDT) for gonorrhea and chlamydial infection when partners are notified via provider referral.
- Because single-dose oral therapy is used for gonorrhea and chlamydial infection, programs should consider patient-delivered partner therapy (PDPT) for partners who will not be notified via provider referral.
- Programs should be sure that all appropriate parties are consulted to ensure that any expedited partner therapy (EPT) strategy in the jurisdiction is medically and legally sound. Appropriate parties vary by jurisdiction but might include state health commissioners or legislative bodies.

HIV Infection

- Program managers should create strong referral linkages with HIV care providers and case managers to help ensure that the medical needs of HIV-infected partners are addressed.
- Partners who test positive for HIV should be linked as soon as possible to early intervention services, medical care, and HIV case management, through which they can receive complete medical evaluations and treatment, assessment, referral for psychosocial needs, and additional prevention counseling.
- Follow-up should be conducted to verify that HIV-infected partners have accessed medical care or HIV case management at least once.
- Partner services programs implementing postexposure prophylaxis (PEP) should develop protocols to ensure that persons exposed to HIV within the previous 72 hours are informed of the option of PEP, including risks and

benefits as they relate to the exposure risk. Staff members conducting partner services should be aware of the options for persons to access PEP, whether through existing programs, urgent care facilities, emergency departments, or private physicians.

Referring Partners to Other Services

- Because of the diverse needs of partners, program managers should identify referral resources for psychosocial and other support services. DISs routinely should be provided updated information about referral resources.
- Many referral needs of partners testing positive for HIV will be addressed through linkage to early intervention, medical care, and HIV case management; however, DISs should screen for immediate needs and make appropriate referrals.
- Partners testing negative for HIV should be screened and referred for other medical and psychosocial needs and prevention services.

Specific Populations

Youths

- Programs should have specific protocols in place to guide partner services for youths. Protocols should address assessment of maturity and extent of social support, use of age-appropriate counseling and communication models, provision of services in youth-friendly environments, and assessment for physical and sexual abuse. These protocols should be developed in collaboration with legal counsel to ensure that they are consistent with all applicable laws and regulations.
- Program managers should ensure that all staff members are aware of state and local requirements related to reporting of suspected sexual activity involving an adult and a minor child, child abuse, and sexual crimes. DISs providing services to youths should be sure to discuss the possibility of sexual abuse with their clients and, if sexual abuse is suspected, should notify the appropriate authorities (e.g., child protective services agency) in accordance with applicable laws and regulations.
- Program managers should ensure that partner services staff members remain knowledgeable and updated on state and local laws and regulations related to parental consent, diagnosis and treatment of STDs, and HIV counseling and testing. If doubt or confusion arises regarding a specific case, legal counsel should be sought.
- Program managers should ensure that any staff person who conducts elicitation of partner names and notification of partners for youths has received training on conducting services in a way that is appropriate for each child's age and developmental level. Training should include ways to recognize and address child abuse or sexual abuse situations.

Immigrants and Migrants

- Program managers should review epidemiologic and other data to identify potential immigrant and migrant populations at high risk for infection in their jurisdictions and be prepared to provide partner services that are linguistically and culturally appropriate.

- Based on the immigrant and migrant needs identified in the community, program managers should develop partnerships with community-based organizations (CBOs) and health-care providers that can deliver linguistically and culturally appropriate care, treatment, prevention, and support services.
- Program managers should consider the diversity training needs of DISs who are working with the immigrant and migrant populations. In particular, staff members conducting interviews should be sensitive to cultural norms governing the discussion of sex and sexual behaviors. To the extent possible, clients who have limited ability to speak English should be interviewed in their native language.
- Programs should consider the literacy level of their clients as well as the primary (or only) language of the clients. Programs should ensure that HIV and STD prevention educational materials are available in appropriate languages that reflect the cultural norms of the population.
- Because of the geographic mobility of immigrants and migrants, program managers should consider use of rapid HIV tests and active outreach strategies for migrant and seasonal workers in nontraditional settings.
- Health jurisdictions should consider developing collaborative agreements with bordering countries (i.e., Canada and Mexico) to assist with notification and follow-up of partners.
- Program managers should be aware of federal, state, and local laws and regulations that might affect partner services for undocumented immigrants.

Incarcerated Populations

- Program managers should become familiar with the federal, state, or county jail and correctional facilities in their jurisdictions. They should meet with key personnel in correctional facilities to discuss the services offered and goals of partner services as a public health intervention, the need for public health staff members to have access to facilities and adequate private space to meet with clients, and ways that partner services activities can be integrated into the facility response plans that are required by the Prison Rape Elimination Act of 2003 (PREA). Follow-up meetings to facilitate communications and coordination should be held periodically.
- Program managers and key correctional facility personnel should establish a formal written agreement to clearly outline roles and responsibilities for both public health and correctional facility staff members.
- Program managers should collaborate with correctional facility staff members to develop protocols for partner services staff members to follow while in the facility, especially during emergencies. Ensuring that partner services staff members know and adhere to facility rules and regulations also is essential. Not adhering to the rules and regulations of a correctional facility will jeopardize implementation and continuation of the partner services program.
- Program managers should collaborate with correctional facility staff members to develop protocols regarding administration of partner services for named partners within a correctional facility.

CLINICAL ALGORITHM(S)

The following clinical algorithms are provided in the original guideline document:

- Logic model for partner services programs for human immunodeficiency virus (HIV) infection, syphilis, gonorrhea, and chlamydial infection
- Steps in the process for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

Published, scientific, evidence-based information on partner services is limited. To the extent possible, the recommendations in this report were based on published evidence. However, when published evidence was lacking or insufficient, recommendations were based on program experience, with input from subject-matter experts.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate use of public health resources to identify infected persons, notify their partners of their possible exposure, and provide infected persons and their partners a range of medical, prevention, and psychosocial services

Short Term Benefits

- Improved patient health
- Reduced infectiousness
- Positive behavior changes

Intermediate Benefits

- Decreased sexually transmitted disease (STD)/human immunodeficiency virus (HIV) morbidity and mortality
- Decreased STD/HIV transmission
- Increased public health knowledge of transmission networks

Long Term Benefits

- Reduced STD/HIV incidence
- Reduced costs
- Improved public health

POTENTIAL HARMS

Challenges for partner services include whether the services will be accepted by patients, the potential for abuse resulting from partner notification, and potential negative effects on relationships after partner notification.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These recommendations are not intended to provide sufficient detail to be used as an operational or instructional manual for the daily activities of disease intervention specialists (DISs), nor are they intended to be used as a substitute for a training manual or curriculum. Although the recommendations address several legal concerns related to partner services, they do not provide a review of law relevant to partner services and should not be considered legal advice. The Centers for Disease Control and Prevention (CDC) provides partner services training for public health staff members; future implementation planning (including training) will incorporate these revised recommendations. These recommendations also are not intended to provide specific technical guidance and program requirements for CDC grantees. That information can be found in sexually transmitted disease (STD) and human immunodeficiency virus (HIV) funding opportunity announcements and related supplemental guidance.
- HIV and STD prevention programs exist in highly diverse, complex, and dynamic social and health service settings. Substantial differences exist in disease patterns, availability of resources, and range and extent of services among different health department jurisdictions. The recommendations should be used in conjunction with local area needs, resources, and laws. HIV and STD prevention programs should establish priorities, examine options, calculate resources, evaluate the distribution of the diseases to be prevented and controlled, and adopt strategies appropriate to their specific circumstances.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Strategies to Enhance Case Finding and Partner Notification

Core Areas

- Health departments should assess the geographic concentration of gonorrhea and consider focusing provider-referral partner notification in core areas.

Social Networks

- Programs should assess the social networks that influence disease transmission in the area as a strategy for finding persons who are at risk for disease but have not been identified by an index patient or partner.
- This strategy should be used to enhance case finding, considering relevant epidemiological and behavioral information.

The Internet

- When an index patient indicates having Internet partners, the disease intervention specialist (DIS) should attempt to obtain identifying and locating information about the partners (e.g., e-mail addresses, chat room handles, and names of chat rooms or websites where the partner might be located).
- Internet partner notification is recommended for partners who cannot be contacted by other means or can be more efficiently contacted and notified through the Internet. This type of notification includes ensuring policies and protocols are in place to 1) ensure that confidentiality or anonymity of the index patient and partners are maintained on the Internet and 2) eliminate structural and bureaucratic barriers to staff member use of the Internet for partner notification.
- Partner services programs should collaborate with community partners to develop strategies for addressing structural challenges to health department–mediated Internet partner notification.

Program Collaboration and Service Integration

- To the extent possible, partner services program managers should ensure that persons receive coordinated human immunodeficiency virus (HIV) and sexually transmitted disease (STD) prevention and related social services, particularly when the persons are affected by more than one disease.
- Partner services program managers should assess and eliminate barriers to programmatic collaboration and service integration within the jurisdiction so that, at a minimum, services are well integrated at the client (i.e., service delivery) level.
- Partner services program managers should ensure that shared protocols and policies are developed to help coordinate partner services for persons identified through HIV or STD clinics or other health department clinics.
- Partner services program managers should encourage private medical care providers to support partner services through active communication mechanisms (e.g., by visiting key medical providers, making presentations about partner services at local and state meetings of providers of HIV care, mailing educational brochures, or providing a summary of these recommendations).
- Partner services program managers should establish systems of communication and information to ensure widespread distribution of these recommendations to health department partners, medical providers, and community-based organizations (CBOs).
- HIV program managers should ensure that communication and information about the partner services recommendations are shared with HIV prevention community planning groups (CPGs).
- Partner services programs should ensure that clearly defined, written protocols and procedures that address confidentiality and data security are in place to address incoming and outgoing requests for intrastate and interstate transmission of information.

Program Monitoring, Evaluation, and Quality Improvement

- Partner services programs should be monitored closely to assess program performance and identify areas that need improvement.

- Monitoring should be designed to answer specific questions about program performance; all data collected should be clearly related to answering these questions.
- Data should be analyzed and reviewed regularly and used to improve program effectiveness and efficiency.
- At a minimum, the following questions should be addressed through monitoring:
    - How completely is the program identifying newly reported cases and interviewing patients for partner services?
    - How effectively is the program identifying partners, notifying them of their risk, and examining or testing them for infection?
    - How effectively is the program identifying new cases of syphilis, gonorrhea, and chlamydial infection through partner services? How effectively is the program treating patients through partner services? How effectively is the program identifying new cases of HIV infection and linking patients to care services through partner services?
    - Do any measures indicate variations by index patient age, race/ethnicity, sex, or risk behavior?
- Programs should establish specific objectives for essential steps in the partner services process and continuously track progress toward achieving these objectives.
- All partner services programs should develop and implement quality improvement procedures and ensure that program staff members receive orientation and training on quality improvement.
- Responsibility for conducting quality improvement procedures should be clearly assigned to a specific person or persons.
- Quality improvement activities should be conducted at regular, scheduled intervals (e.g., quarterly or more often if needed).
- Program staffing infrastructure should include enough staff members who have specific training and expertise in technical supervision of partner services activities to supervise DISs. Quality improvement and review of performance of staff members should be made clear priorities for supervisors.

Support of Staff Members

- Programs should develop and implement comprehensive training plans for partner services staff members at all levels, including program managers and supervisors. All staff members should receive initial training at the time of employment and updates at least annually. Initial training for DISs should include the Centers for Disease Control and Prevention (CDC) training course Introduction to STD Intervention or equivalent, and training for managers should include the CDC training course Fundamentals of STD Intervention or equivalent (course information available at http://www.cdc.gov/std/training/courses.htm). Staff members also should receive training in public health laws and regulations relevant to partner services.
- Programs should use a balance of quantitative and qualitative methods for assessing the performance of individual staff members at all levels (including program managers and supervisors) and developing strategies for improvement.
- Programs should develop and maintain written policies and procedures for maximizing safety of staff members, including policies and procedures that

help staff members avoid occupational exposure to infections and procedures for addressing any exposure that occurs. Policies and procedures should be reviewed and updated at least annually.
- DISs should receive initial and periodic (at least annually) training and orientation on policies and procedures related to workplace safety and should be required to follow them.
- At a minimum, local policies and procedures should encompass applicable policies of the Occupational Safety and Health Administration (available at http://www.osha.gov).

See also Appendix D in the original guideline document for guiding principles and standards for record keeping and data collection, management, and security for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection.

IMPLEMENTATION TOOLS

Clinical Algorithm
Patient Resources
Resources
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention (CDC). Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection. MMWR Recomm Rep 2008 Nov 7;57(RR-9):1-83; quiz CE1-4. [243 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

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GUIDELINE DEVELOPER(S)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

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GUIDELINE COMMITTEE

Partners Services Work Group

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GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site:

- HTML Format
- Portable Document Format (PDF)

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- A continuing education activity is available from the Centers for Disease Control and Prevention (CDC) Web site.
- Sexually transmitted disease (STD) prevention training courses are available for disease intervention specialists (DISs) and supervisors from the CDC Web site.
- Partner services fact sheets and a CDC podcast are available from the CDC Web site.

PATIENT RESOURCES

The following is available:

- FAQs for the public and consumers of partner services activities are available from the CDC Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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